MARKET CONDUCT EXAMINATION

DENTAL HEALTH SERVICES INC.

936 N. 34TH Street, Suite 208
Seattle, Washington 98103

January 1, 2004 – June 30, 2005

Exhibit A
Order No. G06-44
Dental Health Services, Inc.

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The Honorable Mike Kreidler
Washington State Insurance Commissioner
302 14th Avenue SW
P.O. Box 40258
Olympia, Washington 98504-0258

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.44.145 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed of:

Dental Health Services Inc., NAIC #47490
936 N. 34TH Street, Suite 208
Seattle, Washington 98103

In this report, Dental Health Services Inc. is referred to as DHS or as the Company.

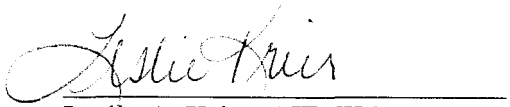
This report of examination is respectfully submitted.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Nancy L. Campbell, AIE, ACS; Jeanette M. Plitt, CLU; and Richard E. Zamudio of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of Dental Health Services Inc. during the course of this market conduct examination.

I certify that this document is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner and that this report is true and correct to the best of my knowledge and belief.



Leslie A. Krier, AIE, FLMI
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

This examination was completed by applying tests to each examination standard. Each test applied during the examination is stated in this report and the results are reported. Exceptions are noted as part of the comments for the applied test. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

Scope

Time Frame

The examination covered the Company's operations from January 1, 2004 through June 30, 2005. This was the first market conduct examination of Dental Health Services Inc. This examination was performed in the Seattle OIC office and at the office of Dental Health Services Inc.

Matters Examined

The examination included a review of the following areas:

Claims
Rate and Form Filing
Administrative Contracts
Provider Activity
Underwriting

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance

Regulatory Standards

Market conduct samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as met. The standards in the area of agent licensing and appointment, and policy and form filings will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

Standards will be reported as Passed (without Comment), Passed with Comment or Failed. The definition of each category follows:

Passed	There were no findings for the standard.
Passed with Comment	Errors in the records reviewed fell within the tolerance level for that standard.
Failed	Errors in the records reviewed fell outside of the tolerance level established for the standard.

COMPANY OPERATIONS AND MANAGEMENT

Company History

Dental Health Services, Inc. (DHS) was incorporated on June 1, 1984. The Company was issued a certificate of registration as a health care service contractor on October 18, 1984. The Company's health care service contractor certificate of registration was converted to a limited health care service contractor certificate on May 31, 1991. The Company is a wholly-owned subsidiary of Dental Health Services of America. The Company administers prepaid dental health care services in the State of Washington.

Company Management & Operations

The directors for Dental Health Services, Inc. are Gary Pernell and Godfrey Pernell, DDS. The officers of the corporation are:

Godfrey Pernell, DDS, President
Gary Pernell, Secretary/Treasurer
Mehdi Moussavi, Chief Financial Officer

Findings

The following Company Operations & Management Standards passed without comment:

#	Company Operations & Management Standard	Reference
1	**The company is required to be registered with the OIC prior to acting as a health care service contractor in the State of Washington.**	**RCW 48.44.015(1)**
2	**The company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State.**	**RCW 48.44.013**
3	**When the company registers with the OIC, it is required to state its area of operations.**	**RCW 48.44.040**

It should be noted that the market conduct examiners did not review DHS's registration documents. These documents were reviewed as part of the OIC's financial examination for the period ending December 31, 2002. The financial examiners found DHS complies with these standards.

GENERAL EXAMINATION FINDINGS

The Company's records and operations were reviewed to determine if the Company does business in accordance with the requirements of this state.

Findings

The following General Examination Standards passed without comment:

#	General Examination Standard	Reference
1	**The company does business in good faith, and practices honesty and equity in all transactions.**	**RCW 48.01.030**
2	**The company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request.**	**RCW 48.44.145(2)**
3	**The company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC.**	**WAC 284-30-572(2)**

CLAIMS

Claims Procedures

The Company provided the examiners with its claims procedures that were in effect during the examination period. The examiners noted three (3) sections in the procedures that contained language in violation of statute or code:

- The company referred to itself as a health maintenance organization (HMO). RCW 48.46.027(1) requires registration with the Commissioner in order to represent oneself as an HMO.
- The interest due on unpaid claims is incorrect. The Company's procedures stated that claims not paid within 30 working days would include interest at the rate of 15% per annum or $15, whichever is greater. This interest schedule is in violation of WAC 284-43-321(2)(ii)(d). Further discussion can be found on page 10 of this report.
- The time requirements regarding pre-authorization appeals and post-service appeals are incorrect and in violation of WAC 284-43-620(1). Appeals must be reviewed within 14 days of receipt rather than 30 days as stated in the procedures.

Subsequent Event: DHS submitted revised procedures to the examiners on November 17, 2005. All items noted are now in compliance. The procedures were effective immediately.

Claims Processing

DHS offers prepaid capitated and reimbursement dental benefits. Claim forms are not required for prepaid general dentist services. DHS processes an average of 2,474 capitated claims per month. Claim forms are used for specialty care, such as referrals to specialists and emergency services. The majority of the specialty care claims received by the Company are sent through the mail. DHS receives approximately one (1) to two (2) claims per week for Washington members for specialty care. These are entered into the system manually by claims processors. Claim information is reviewed for accuracy, appropriateness of service, benefit guidelines, and coverage. In addition, eligibility is verified by the claim system automatically on a real time basis during the processing of each claim. If a claim cannot pass through the system automatically, it is suspended and referred to a specialist who researches and determines how the claim should be processed.

The average processing time for a claim is 10 working days. Company standards call for payment within 30 working days. Random internal auditing is conducted on a quarterly basis. Internal auditing performed by DHS confirms that payment and dollar accuracy is consistently at or above 98 percent.

Claims Review

DHS processed 47,505 capitated claims and 411 specialty claims during the examination period. The examiners reviewed internal auditing of the Company's capitated claims and selected a random sample of 50 specialty care claims for review.

Standard #6 was not tested in this examination. DHS excludes coordination of benefits in its contracts.

The following Claims Standards passed without comment:

#	Claims Standard	Reference
1	**The company shall provide no less than urgent and emergent care to a child who does not reside in the company's service area.**	**RCW 48.01.235(3)**
2	**The company shall not retrospectively deny an individual prescription drug claim that had prior authorization.**	**RCW 48.44.465**
3	**The company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefit if services were performed by a dentist.**	**RCW 48.43.180, RCW 48.44.500**
5	**The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied.**	**WAC 284-43-321(4)**

The following Claims Standards passed with comment:

#	Claims Standard	Reference
4	**The company shall pay or deny claims subject to the required minimum standards. The company pays interest on undenied and unpaid clean claims that are more than 61 days old.**	**WAC 284-43-321(2)**

Claims Standard #4:

The Company's procedures stated that claims not paid within 30 working days would include interest at the rate of 15% per annum or $15, whichever is greater. This interest schedule is in violation of WAC 284-43-321(2)(ii)(d). The examiners performed analysis on the claims database and confirmed that all claims were paid or denied correctly and within the timeframe required by code.

Subsequent Event: DHS submitted revised procedures to the examiners on November 17, 2005. All items noted are now in compliance. The procedures were effective immediately.

COMPLAINT HANDLING

The original scope of the examination did not include complaint handling. During the course of claim reviews, the examiners discovered that the time requirements regarding pre-authorization appeals and post-service appeals are incorrect and in violation of WAC 284-43-620(1). Appeals must be reviewed within 14 days of receipt unless the company notifies the covered person of the delay. The company materials state that the company must respond within 30 days.

The following Complaint Handling Standard failed:

#	Complaint Standard	Reference
1	A company must review an appeal within 14 days of receiving the request unless the company can reasonably show that an extension is required. In no case, shall the company take more than 30 days to reply to an appeal.	WAC 284-43-620(1)

RATE AND FORM FILING

Rate and Form Filing Review

In conjunction with the review of underwriting files, the examiners compared the rates and forms filed by DHS to the rates that were billed to each group and to each individual, and to

the forms that were issued. The Company filed five (5) contracts during the examination period with corresponding rates for each plan. The examiners reviewed 50 group files and 100 individual files.

Findings

The following Rate and Form Filing Standards passed without comment:

#	Rate and Form Filing Standard	Reference
1	**All contract forms have been filed with and approved by the OIC prior to use.**	**RCW 48.44.040, WAC 284-43-920**
2	**All rates have been filed with the OIC prior to use.**	**RCW 48.44.040, WAC 284-43-920**
3	**All contract forms and rates have been filed with the OIC on transmittal forms prescribed by and available for the Commissioner.**	**WAC 284-43-925**

UNDERWRITING

Underwriting Procedures

DHS provided its group plan and individual plan underwriting procedures. The procedures accurately describe the Company's processes.

Underwriting Process

New groups that want to enroll submit a master application, individual enrollment forms, and the first month's premium to the Company. The information is verified and entered into the system, a group number is assigned, and administrative materials are sent to the group. These materials include a welcome letter, group administrative manual, and group service agreement. These materials, along with identification cards, evidence of coverage brochures, and a schedule of covered services and copayments, are mailed within five (5) business days of group acceptance.

Individuals who want to enroll submit an application along with the first month's premium. Each enrollee receives a call from the Company to confirm their enrollment. Each subscriber is mailed a membership card, evidence of coverage brochure, and a schedule of covered services and copayments. These materials are mailed within five (5) business days of receipt of the enrollment application.

Underwriting File Review

The following is a breakdown of the population and number of files selected for review:

Type of Plan	Total Population	Sample Size Selected
Individual Plans	13,450	100
Group Plans	6,752	50
Total	**20,202**	**150**

The examiners reviewed the files to assure:

- Rates and benefits were appropriate to the group or individual demographics.
- Individuals and members of groups were not unfairly denied coverage.
- Notifications of renewal action or termination were provided in a timely manner.
- The Company's underwriting guidelines were applied consistently throughout the sample.

Findings

The following Underwriting Standards passed without comment:

#	Underwriting Standard	Reference
1	**The company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent.**	**RCW 48.01.235**
2	**Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap.**	**RCW 48.44.210**
3	**All plans shall cover newborn infants and congenital anomalies from the moment of birth.**	**RCW 48.44.212(1)**
4	**No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap.**	**RCW 48.44.220**
5	**Adoptive children shall be covered on the same basis as other dependents.**	**RCW 48.44.420**
6	**All cancellations, denials, or non-renewals of an individual plan must be in writing and include the reason for such action.** *Individual Coverage Only*	**RCW 48.44.260**
7	**Dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee.**	**RCW 48.44.400**
8	**All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ) and maintain proof of offer as required.** *Group Coverage Only.*	**RCW 48.44.460 WAC 284-44-042**

#	Underwriting Standard	Reference
9	**An individual may return an individual health care contract for a full refund within ten (10) days of its delivery if not satisfied with the contract for any reason.** *Individual Coverage Only*	RCW 48.44.230

PROVIDER ACTIVITY

Provider Contracting Process

The Company contacts providers and requests their network participation based on need in geographical areas, referrals from members, and referrals from agents. After a prospective dentist is identified, information is sent to them regarding participation in the DHS network of providers. If that information is returned, the credentialing process begins. After a dentist is accepted as a participating provider, the Company visits the dentist's office and conducts training on the procedures used by DHS.

Provider Manuals

The Company provided the examiners with its provider manual. The manual is comprehensive and clearly outlines the processes and procedures used by DHS in the administration of its dental plans.

Provider Contract Review

There were three (3) provider contracts in use during the exam period: provider agreement, specialist agreement, and denturist agreement. There were a total of 104 dental professionals contracted with DHS during the examination period. Each provider has the most recently filed contract based on his specialty.

Findings

The following Provider Activity Standards passed without comment:

#	Provider Activity Standard	Reference
1	**All provider contract forms must be filed with and approved by the OIC prior to use.**	**RCW 48.44.070 WAC 284-43-330**
2	**All provider contract forms must contain and adhere to the prescribed standards.**	**WAC 284-43-320 through WAC 284-43-340**

#	Provider Activity Standard	Reference
3	**Company standards for selection of participating providers and facilities do not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas.**	**WAC 284-43-310(1)(a) and (b)**

ADMINISTRATIVE CONTRACTS

The Company provided the examiners with three (3) administrative contracts that were in place during the examination period:

- Agreement between the Company and Dental Health Services of America (DHS-AM). DHS-AM provides general management services and professional liability, property, business and comprehensive general liability insurance coverage.
- Agreement between the Company and Dental Health Services (DHS-CA). DHS-CA provides general back office support (claims processing, capitation and enrollment processing, membership services, computer and data processing, accounting and regulatory reporting).
- Agreement between the Company and Dental Health Services (DHS-CA). The Company provides marketing services to DHS-CA.

The agreements are with affiliated companies. There were no areas of concern noted.

INSTRUCTIONS

	INSTRUCTIONS	PAGE #
1	The Company is instructed to cease referring to itself as a health maintenance organization (HMO). Reference: RCW 48.46.027(1). (Claims Procedures.)	8
2	The Company is instructed to review any adverse determinations within 14 days of receipt of an appeal. Reference: WAC 284-43-620(1). (Complaint Handling)	8, 10

RECOMMENDATIONS

	RECOMMENDATIONS	PAGE #
1	The Company is instructed to change its interest payment structure on claims that are not paid within the time limits set forth in regulation WAC 284-43-321(2)(ii)(d). Interest shall be paid on undenied and unpaid clean claims that are more than 61 days old. Reference: WAC 284-43-321(2). (Claims Procedures and Claims Standard #4.)	8, 10

SUMMARY OF STANDARDS

Company Operations and Management:

#	STANDARD	PAGE	PASS	FAIL
1	The company is required to be registered with the OIC prior to acting as a health care service contractor in the State of Washington. Reference: RCW 48.44.015(1).	7	X	
2	The company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State. Reference: RCW 48.44.013.	7	X	
3	When the company registers with the OIC, it is required to state its territory of operations. Reference: RCW 48.44.040.	7	X	

General Examination Findings:

#	STANDARD	PAGE	PASS	FAIL
1	The company does business in good faith, and practices honesty and equity in all transactions. Reference: RCW 48.01.030.	8	X	
2	The company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.44.145(2).	8	X	
3	The company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. Reference: WAC 284-30-572(2).	8	X	

Claims Findings:

#	STANDARD	PAGE	PASS	FAIL
1	The company shall provide no less than urgent and emergent care to a child who does not reside in the Company's service area. Reference: RCW 48.01.235(3).	9	X	
2	The company shall not retrospectively deny an individual prescription drug claim that had prior authorization. Reference: RCW 48.44.465.	9	X	
3	The company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist. Reference: RCW 48.43.180, RCW 48.44.500.	9	X	
4	The company shall pay or deny claims subject to the required minimum standards. The company pays interest on undenied and unpaid clean claims that are more than 61 days old. Reference: WAC 284-43-321(2).	10	X	

#	STANDARD	PAGE	PASS	FAIL
5	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied. Reference: WAC 284-43-321(4).	9	X	
6	The Company administers Coordination of Benefits provisions as required.	9	NA	NA

Complaint Handling:

#	STANDARD	PAGE	PASS	FAIL
1	A company must review an appeal within 14 days of receiving the request unless the company can reasonably show that an extension is required. In no case, shall the company take more than 30 days to reply to an appeal.	10		X

Rate and Form Filing:

#	STANDARD	PAGE	PASS	FAIL
1	All contract forms have been filed with and approved by the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920.	11	X	
2	All rates have been filed with the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920.	11	X	
3	All contract form and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner. Reference: WAC 284-43-925.	11	X	

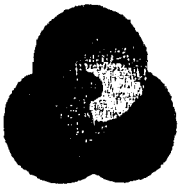
Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	The company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent. Reference: RCW 48.01.235.	12	X	
2	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap. Reference: RCW 48.44.210, RCW 48.44.200	12	X	
3	All plans shall cover newborn infants and congenital anomalies from the moment of birth. Reference: RCW 48.44.212(1).	12	X	
4	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Reference: RCW 48.44.220.	12	X	
5	Adoptive children shall be covered on the same basis as other dependents. Reference: RCW 48.44.420.	12	X	

#	STANDARD	PAGE	PASS	FAIL
6	All cancellations, denials, or non-renewals of an individual plan must be in writing and include the reason for such action. *Individual Coverage Only*. Reference: RCW 48.44.260	12	X	
7	Dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee. Reference: RCW 48.44.400.	12	X	
8	All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ) and maintain proof of offer as required. Reference: RCW 48.44.460, WAC 284-44-042.	12	X	
9	An individual may return an individual health care contract for a full refund within 10 days of its delivery if not satisfied. Reference: RCW 48.44.230	13	X	

Provider Activity:

#	STANDARD	PAGE	PASS	FAIL
1	All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, WAC 284-43-330.	13	X	
2	All provider contract forms must contain and adhere to the prescribed standards. Reference: WAC 284-43-320 through WAC 284-43-340.	13	X	
3	Company standards for selection of participating providers and facilities do not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas. Reference: WAC 284-43-310(1)(a) and (b).	14	X	



Dental
Health
Services

April 20, 2006

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INSURANCE COMMISSIONER
SEATTLE

James T. Odiorne, CPA, JD
Deputy Insurance Commissioner
Company Supervision Division
Office of Insurance Commissioner
5000 Capitol Blvd.
Tumwater, WA 98501

Re: Market Conduct Examination Report – March 30, 2006

Dear Mr. Odiorne:

Dental Health Services respectfully requests that before the OIC's March 30, 2006 Market Conduct Examination Report is finalized and made public by your Office, the following items be amended:

1. COMPLAINT HANDLING – Page 10 of the March 30, 2006 report

The following Complaint Handling Standard Failed:

#	Complaint Standard	Reference
1	A company must review an appeal within 14 days receiving the request unless the company can reasonably show that an extension is required. In no case, shall the company take more than 30 days to reply to an appeal	WAC 284-43-620(1)

In spite of an inadvertent oversight in an internal-use-only document, our Appeals and Disputes procedures which we abide by, are and have been in complete compliance with WAC 284-43-620(1). As indicated in section X. Appeals and Disputes in our Claims Review and Payments Policy and Procedures, all contested or appealed provider claim determinations are treated as grievances. Dental Health Services' Grievance Procedure (WA-200) on file with your office had the correct appeals language, and procedures are and were observed by Dental Health Services' claims department. As noted in the OIC report, on November 17, 2005 Dental Health Services submitted its revised, for internal-use-only Claims Review and Payments Policy and Procedures which included corrected 14 day appeal language placing it in compliance and consistent with our previously filed Grievance Procedure. We are respectfully requesting that the Complaint Handling Standard, item # 1 be changed from "FAIL" to "PASS" with comment.

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Dental Health Services

2. INSTRUCTIONS - Page 15 of the March 30, 2006 report (Item #1)

	INSTRUCTIONS	Page #
1	The company is instructed to cease referring to itself as a health maintenance organization (HMO). Reference: RCW 48.46.027 (1). (Claims Procedures.)	8

As noted in the OIC report, on November 17, 2005 Dental Health Services submitted the revised internal-use-only Claims Review and Payments Policy and Procedures to the examiners and the referenced issue was corrected. The Company recognizes it is a Limited Health Care Services Contractor. This term was only used in an internal-use-only document and at no time made available to the public. The term was removed immediately. We are respectfully requesting that this item be removed from the instructions section as the Examination Report indicates this issue is in compliance on page 8.

3. INSTRUCTIONS - Page 15 of the March 30, 2006 report (Item #2)

	INSTRUCTIONS	Page #
2	The Company is instructed to review any adverse determinations within 14 days of receipt of an appeal. Reference: WAC 284-43-620(1). (Complaint Handling)	8, 10

On November 17, 2005 (as noted in the Examination Report), Dental Health Services submitted the revised internal-use-only Claims Review and Payments Policy and Procedures including the 14-day appeal language, which is consistent with the language pertaining to appeals in our Grievance Procedure (WA-200) on file with your Office. As previously stated, the revised wording corresponds with existing procedures that are and were observed by Dental Health Services. Because Dental Health Services immediately revised the internal-use-only Claims Review and Payments Policy and Procedures to be in compliance with the Office of Insurance Commissioner and our previously filed Grievance Procedure (WA200), we are requesting the elimination of this item from the Instructions section of the Market Conduct Examination Report.

4. SUMMARY OF STANDARDS - Page 17 of the March 30, 2006 report

#	Complaint Standard	Page	Pass	Fail
1	A company must review an appeal within 14 days receiving the request unless the company can reasonably show that an extension is required. In no case, shall the company take more than 30 days to reply to an appeal	10		X

As previously stated, Dental Health Services submitted revised Claims Review and Payments Policy and Procedures on November 17, 2005 to the Office of Insurance Commissioner. This document included required 14 day appeal language, which is included in our filed Grievance Procedure. Dental Health Services has and remains in compliance with WAC 284-43-620(1). Because this was an inadvertent oversight in an internal-use-only document, and we immediately amended the internal document, we are requesting that the "FAIL" score be changed to a "PASS".

Dental Health Services

Consumer protection is the most critical component of our operation. We take our statutory and regulatory responsibilities very seriously and appreciate your consideration of our request to modify the final Examination Report.

If you have any questions or requests. I can be reached at 206.788.3450 or via email at lsunich@dentalhealthservices.com and will be glad to respond and assist.

Sincerely,

Lanell Sunich

Lanell Sunich
Compliance Manager

Cc: Michael G. Watson, Chief Deputy Insurance Commissioner
Leslie Krier, Chief Market Conduct Examiner
Nancy Campbell, Examiner In Charge
Godfrey Pernell, DDS - Chairman
Gary Pernell – CEO
Mehdi Moussavi – CFO and Vice President, Finance
Josh Nace – Vice President, Service